Supreme Court, U.S.
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No. 00-1021

IN THE

# Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

*Petitioner,*

*v.*

DEBRA C. MORAN AND STATE OF ILLINOIS,

*Respondents.*

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

## BRIEF IN OPPOSITION FOR RESPONDENT DEBRA MORAN

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## QUESTION PRESENTED

The Illinois legislature enacted a law in 1987, found in the Illinois HMO Act, as part of the Illinois Insurance Code, which requires independent review of "medical necessity" determinations where there is a dispute between a patient's primary care physician and an HMO operating in Illinois, about the medical necessity of a proposed procedure. The HMO insurer here, Rush Prudential HMO, specifically adopted state law as part of its insurance policy. The Seventh Circuit held that this state insurance law, specifically and solely directed at the insurance industry, was a state law which regulates insurance, exempt from ERISA's preemptive effect, and was a part of defendant's policy as a matter of law. The question Petitioner seeks to present is more accurately posed in the specific factual context of this case as:

> Whether the "independent review" under Illinois insurance law, specifically adopted by an insurer into its HMO insurance policy, which requires an HMO insurer in Illinois to provide independent review where there is a disagreement between a primary care physician and the HMO's medical director over the medical necessity of a proposed service, is a state law that "regulates insurance" and is saved from ERISA preemption by the ERISA savings clause, 29 U.S.C. § 1144(B)(2)(a), thereby allowing application of said state insurance law to protect Illinois insureds.

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## INTRODUCTION

Respondent, Debra C. Moran, respectfully submits that the Petition for Writ of Certiorari should be denied. As this Court expresses in its own Supreme Court Rule 10, "petitions for a writ of certiorari will be granted only for compelling reasons." No such reason exists here. While Respondent does not deny the Seventh Circuit's decision is important because it clarifies the rights of Illinois insureds to enforce the Illinois independent review law, the Seventh Circuit's decision is a straight-forward, proper statutory analysis of the legal effect of the ERISA savings clause, 29 U.S.C. § 1144(B)(2)(a), upon a state insurance law. That decision is consistent with the Supreme Court's pronouncements on ERISA preemption, particularly its most recent decision, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999). The Seventh Circuit's decision, based on specific facts, is the classic case decried under this Court's same Supreme Court Rule 10 which states, "a petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law."

Petitioner makes much of Justice Posner's dissent from the denial of rehearing *en banc* below, but in doing so ignores the unanimous decision on this case and the fact the great majority of the Seventh Circuit opposed rehearing the case at all. While it is true some states now have independent review laws, the Illinois law has been in effect for thirteen years and this is the first precedent in Illinois with respect to the preemptive effect of ERISA relating to that law. Further, despite the fact that a number of states now have such laws, it appears only two Federal circuit courts have addressed the issue of preemption of independent review. While Petitioner claims there are now many states with independent

review laws, it makes no showing of how many states have provisions like the one at issue here. Petitioner provides no analysis, for example, of whether the laws of the other 36 states, like the Illinois law, are limited to the insurance industry, as they are in Illinois. This is a key factor in addressing the preemptive effect of ERISA, which would make any Supreme Court review of the Seventh Circuit decision, as applied to the specific Illinois independent review law, of limited effect.

Further, Petitioner fails to advise the Court of the pending federal legislation (commonly known as the "Patient's Bill of Rights") under consideration by Congress. While there is partisan disagreement about the Republican and Democratic sponsored bills pending, the one area on which there has been bipartisan agreement is that any Federal legislation will include an independent review feature for medical necessity decisions. *See* Bipartisan Patient Protection Act of 2001, S. 283, 107th Cong. § 104 (2001) (requiring group health plans and health insurance issuers to provide beneficiaries with "independent external review for any denial of a claim for benefits" and allowing beneficiaries to commence a civil action to recover reimbursement and fees where a plan fails to provide reimbursement pursuant to an external review decision in favor of beneficiary); Bipartisan Patient Protection Act of 2001, H.R. 526, 107th Cong. § 104 (2001) (same); Quality Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong. § 1103 (1999) (requiring health plans and health insurance issuers to provide for an external appeals process of a denial of claim or benefits as medically unnecessary or when the coverage decision requires medical judgment and allowing courts of competent jurisdiction to require health plans that do not abide by external review decisions to impose civil



penalties, cease and desist orders, and payment of attorney's fees and costs); and Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. § 121 (1999) (requiring group health plans and health insurance issuers to provide beneficiaries with access to independent external review of adverse coverage determinations and allowing civil actions or other remedies to recover the amount of unpaid reimbursement required by such review, along with necessary legal costs and expenses, including attorney's fees). Therefore, there is no substantial likelihood that review of this case will resolve the preemption issue or that this particular issue will arise "again and again" as Petitioner insists. Rather, it is more likely, as President Bush declared during his campaign, that a patient's bill of rights will be passed which includes an independent review provision required on a national basis.

This fact specific case involving the interpretation of one portion of an Illinois insurance statute voluntarily adopted by the insurer was properly decided below, in accordance with established precedent, and does not warrant Supreme Court review. The Petition should be denied.

## STATEMENT OF THE CASE

Plaintiff Debra Moran suffered painful and debilitating conditions in her right shoulder. Petitioner's Appendix ("Pet. App.") 3a. She sought treatment within the HMO insurance network of Rush Prudential HMO, Inc. ("Rush" or "Defendant"). This HMO insurance coverage was purchased and provided as an employee benefit through Ms. Moran's husband's employer. It was a fully insured plan. Pet. App. 3a.

Ms. Moran's HMO primary care physician treated her conservatively at first and referred her in-network to a physical therapist and for specialist consults. Pet. App. 3a-4a. She did not improve and her primary care physician recommended to Rush that it approve a proposed surgery out of network. He concluded it would "best serve" his patient. Pet. App. 5a. In addition, the organization responsible for physician services under the fully-insured Rush plan also approved the proposed out of network surgical services. Rush, however, refused to approve the treatment. Pet. App. 5a. Ms. Moran's appeal within the Plan's guidelines was denied. Pet. App. 5a.

Rush is a licensed Illinois HMO which arranges to provide medical services to patients in Illinois. Rush's HMO policy provided:

> If the provisions of this certificate do not conform to the requirements of any state or federal law that applies to this certificate, the certificate is automatically changed to conform with the requirements of that law.

Pet. App. 21a n.4. Rush refused to provide independent review under the Illinois statute, claiming it did not have to because review of its "medical necessity" decision was preempted by ERISA. Pet. App. 5a-7a.

In January, 1998, Ms. Moran filed suit in state court in Illinois seeking appointment of an independent review physician and enforcement of the Illinois Independent Review Law. Pet. App. 7a. As Ms. Moran's pain and disability was increasing, she paid for the services herself and had the surgery performed out of network. Pet. App. 6a.



The state court ordered independent review. Pet. App. 7a. The parties agreed on the independent reviewer and he submitted his independent review report which found the out of network services were medically necessary. Pet. App. 7a-8a.

Despite the independent reviewer's conclusion, Rush refused to reimburse Ms. Moran for the money she spent to obtain the surgery, hospitalization, and follow-up benefits and care she needed to repair her shoulder. Pet. App. 8a. Ms. Moran asked the state court to enforce the independent review law pursuant to her original prayer for relief. Pet. App. 8a.

In February, 1999, Rush removed to Federal Court on the basis of complete preemption. Pet. App. 8a. The District Court then granted Defendant's Motion for Summary Judgment on Plaintiff's ERISA claims and her claims for breach of fiduciary duty. Pet. App. 9a-10a.

Plaintiff Debra Moran appealed and the Seventh Circuit Court unanimously reversed on October 18, 2000, finding that § 4-10 was not preempted by ERISA, but instead was exempt from preemption by virtue of the savings clause, as a state law which regulates insurance, and therefore finding Debra Moran entitled to summary judgment in her favor. Pet. App. 1a-24a.

## REASONS FOR DENYING THE WRIT

## I.

## THE DECISION IS CORRECT.

### A. The Illinois Law Regulates the Content of the Insurance Contract.

This action falls squarely under the Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), finding a mandated benefit law requiring minimum mental health benefits exempt from ERISA preemption. The only difference is here "medical necessity" (and hence coverage) is determined on a case by case basis in the rare event a primary case physician within an HMO disagrees with its medical director. Nothing in ERISA prohibits this. The statutory wisdom of the law was determined by the Illinois legislature in a classic act of state insurance regulation.

In contrast, this case does not fall, as Petitioner suggests, under the Court's reasoning in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), because it does not provide a different state cause of action and remedy than ERISA. Rather, it provides a substantive, mandated insurance term, which (if the insurance is purchased by an ERISA plan) can be enforced under ERISA, just as the Seventh Circuit concluded. Pet. App. 23a. In *Pilot Life*, Plaintiff sought to enforce state common law causes of action for tortious breach of contract, breach of fiduciary duty and improper claims processing, and sought, *inter alia*, attorneys' fees and punitive damages. 481 U.S. at 43-44. Since § 502 (29 U.S.C. § 1132(a)) itself provides for attorneys' fees and makes no provision for



punitive damages, the court found the claims preempted by ERISA. 481 U.S. at 53-54. But § 502 specifically permits an action "to recover benefits due . . . under the terms of his plan, or to enforce his rights under the terms of the Plan. . . ." 29 U.S.C. § 1132(b)(1)(B). That is what Debra Moran sought here: to recover benefits under and to enforce her rights under the terms of her plan which purchased insurance with an adopted, state mandated independent review provision. She did not seek punitive damages or attorney's fees under state common law. She did not seek to invoke any remedy other than those provided under ERISA.

A common sense review of the issue confirms the Seventh Circuit's decision. There is no doubt that an HMO insurer could voluntarily adopt an independent review provision in its insurance contract (as Rush did here). Indeed, nothing in ERISA's substantive scheme or its enforcement provision, § 502, prohibits such a provision. It follows that if a plan can voluntarily purchase insurance with an independent review provision, then a state, via the insurance regulation exception to ERISA preemption, can require it. That is what occurred here. In the *Pilot Life* case, however, the plan could not voluntarily agree to subject itself to state common law causes of action for damages not covered under ERISA — it could not "agree" that ERISA's enforcement § 502 would not apply — and thus this Court held state common law did not apply.

The issue becomes clearer when viewed in the context of the legal presumptions relating to preemption. Here, ERISA provides an express exception to preemption for state insurance regulation. This Court has indicated that "where Federal law is said to bar state action, a field of traditional state regulation, the Court has worked on the assumption

that the historic police powers of the states were not to be superseded by the federal law unless that was the clear and manifest purpose of Congress." When a party is seeking to apply federal law there is the considerable burden of overcoming the "starting presumption that Congress does not intend to supplant state law." *DeBuono v. NYSA-ILA Med. & Clinical Servs.*, 520 U.S. 806, 820 (1997). By saving such insurance regulation from preemption, ERISA "leaves room for complimentary or dual federal and state regulation of the insurance industry." *John Hancock Mutual Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 98 (1993). The Seventh Circuit below, the Fifth Circuit and even Justice Posner in dissent, all agree an independent review law falls within the state insurance exception. Respondent submits that to imply that the express exception does not apply because of a conflict with another portion of the statute (*i.e.*, enforcement § 502), there must be a direct conflict where, for example, it would be impossible to comply with the state insurance regulation and ERISA. Such an extreme case is not present here.

This Court gave effect to the facially unrestricted scope of the insurance savings clause in *Metropolitan Life* when it "declined to impose any limitation on the savings clause beyond those Congress imposed in the clause itself and in the 'deemer' clause which modifies it," and concluded that "if a state law 'regulates insurance' as mandated - benefit laws do, it is not preempted." 471 U.S. at 746; *cf. Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected any interpretation of the [insurance] savings clause . . . that saved from preemption 'only state regulations unrelated to the substantive provision's of ERISA' "). In addition, the force of the savings provision's express terms is reinforced by the Supreme Court's frequent recognition



— particularly in recent cases — that ERISA preemption provisions must be read against the background of the "assumption that the historic police powers of the states were not to be superseded by the Federal act unless that was the clear and manifest purpose of Congress." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). The decision finding no preemption below was correct. There is no need for Supreme Court review.

### B. The Independent Review Law Is a Part of Defendant's Insurance Contract.

The Seventh Circuit's decision distinguishes it from the Fifth Circuit decision in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor v. Corporate Health Ins., Inc.*, 169 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665) and is exactly right as a matter of law. The Court explained that the provisions of § 4-10 of the HMO Act were incorporated into Ms. Moran's insurance contract, noting that the certificate defining Ms. Moran's rights under the Plan voluntarily incorporated the provisions of § 4-10 specifically. Pet. App. 21a n.4. The Court concluded that "thus, a suit by her to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan; precisely the sort of suit that is contemplated by § 502(A)(1)(b) 'to enforce rights' and to 'recover benefits' under the plan." Pet. App. 21a. Thus, the Seventh Circuit unanimously concluded that the HMO Act

> requires entities in the business of insurance to provide additional safeguards to preserve the integrity of the decision making process.

> Following the example of the Supreme Court of the United States, we believe that such requirements ought to be treated as mandated contract terms and treated as part of the insurance contract. *See Ward*, 526 U.S. at 375-76; *see also Plumb*, 124 F.3d at 861.

Pet. App.3a.

### C. The Independent Review Is Enforceable Through ERISA.

Petitioner's argument that even if the Illinois law were saved by the savings clause from ERISA preemption the provision violates the exclusivity of the ERISA civil enforcement scheme, is also contrary to the most recent Supreme Court precedent on the issue in *UNUM Life Ins. Co. v. Ward*. There, this Court specifically stated:

> Unum and its *amici* assert that even if the notice-prejudice rule is saved under 29 U.S.C. §1144(b)(2)(a), it is nonetheless preempted because it conflicts with substantive provisions of ERISA in three ways. The ruling first contends that the notice-prejudice rule, by altering the notice provisions of the insurance contract, conflicts with ERISA's requirement that plan fiduciaries act "in accordance with the documents and instruments governing the plan." §1104(a)(1)(d). According to Unum, §1104(a)(1)(d) preempts any state law contrary to a written plan term.
>
> Unum's "contra-plan term" argument overlooks controlling precedent and makes scant sense. We



> have repeatedly held that state laws mandating insurance contract terms are saved from preemption under §1144(b)(2)(a). *See Metropolitan Life*, 471 U.S. at 758. ("Massachusetts' mandated benefit law is a law which regulates insurance and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA"); *FMC Corp.*, 498 U.S. at 64 ("If a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts"). Under Unum's interpretation of §1104(a)(1)(d), however, states would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by asserting a contrary term in plan documents. This interpretation would virtually "write the savings clause out or ERISA." *Metropolitan Life*, 471 U.S. at 741.

*UNUM*, 526 U.S. at 375-76.

As *UNUM* argued, Rush now argues in seeking review, that its policy language gives it unlimited discretion to determine "medical necessity" and displaces the state regulation via § 4-10, which requires independent review to determine medical necessity. According to this argument, Illinois is powerless to alter the terms of an insurance policy purchased by fully-insured ERISA plans because Rush, as the insurer, displaced state regulation simply by inserting a contrary term in the plan documents. As in *UNUM*, this interpretation writes the savings clause out of ERISA and renders the Illinois legislature's efforts to regulate HMO insurance in Illinois, across the board, ineffective as to

ERISA fully-insured plans. This is contrary not only to the intent of the Illinois Congress but also to Federal Congressional intent with respect to the savings clause.

If Rush's argument is correct, this means that while the state court and Seventh Circuit Court of Appeals below both found the Illinois provision requiring independent review is not preempted, any efforts to enforce the results of that independent review are supposedly "preempted" under ERISA. This would "pull the teeth" of the Illinois Independent Review statute. Under this argument, while independent review can be required, it has no force or effect and can be disregarded by the HMO insurer, at it was in this case. As a matter of statutory construction, Illinois state and federal courts can enforce the provisions of the Illinois Independent Review statute with respect to fully insured HMO plans operating under Illinois law, and require payment where the independent reviewer concludes there is medical necessity, even if the insured plan is provided under an ERISA plan.

The effect of Rush's argument to this Court is that Rush's "medical necessity" insurance decision must be accorded deference and can only be reviewed according to an arbitrary and capricious standard, even in the face of state insurance law to the contrary. Yet, ERISA does not contain any provision requiring review of an insurance decision according to an arbitrary and capricious standard.[1] Rush cites

1. Even if this argument were correct, *Hightshue v. AIG Life Insurance Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998), provides that ERISA insurers, as fiduciaries "are obligated at a minimum to engage in an intensive and scrupulous *independent* investigation of their options to insure that they act in the best interest of the plan (Cont'd)



no ERISA law or regulation which requires that a claims administrator for insurance purchased by a plan must have exclusive authority to apply and interpret the terms of the insurance. By virtue of the savings clause, the states are free to regulate insurance in this area by enacting review provisions. The independent review law does just that. This type of substantive regulation by state insurance laws is exactly what § 514(b) exempts from ERISA preemption.

### D. The Independent Review Law Is A State Insurance Law.

In reaching its conclusion, the Seventh Circuit confirmed that the Illinois Independent Review Provision, § 4-10, was incorporated into the HMO's insurance contract as a matter of law. Pet. App. 13a. The Court also made a thorough statutory analysis of ERISA's savings clause, § 514(B)(2)(a), which qualifies § 514(a) by excepting state laws from preemption when those laws "regulate insurance." Pet. App. 14a. The Court followed Congress' express intent to exempt state laws which regulate insurance from ERISA preemption via the ERISA savings clause. This decision is consistent with this Court's pronouncements on the broad exemption supplied by the savings clause. *See Metropolitan Life Ins. Co.*, 471 U.S. at 733 (holding that ERISA preemption is "substantially qualified by this insurance savings clause.")

The Seventh Circuit's unanimous decision followed the Supreme Court's pronounced standards for determining

(Cont'd)
beneficiaries" (emphasis added). Thus even under ERISA itself independent review would be required here with respect to Plaintiff's alternative claim for arbitrary and capricious conduct, so Supreme Court review is unnecessary.

whether a particular state law "regulates insurance." The Court followed this Court's holding in *Metropolitan Life Ins. Co.*, 471 U.S. 740 that to determine whether a state law "regulates insurance" within the meaning of the savings clause, the court first asks "whether, from a 'common sense view of the matter,' that the contested prescription regulates insurance." The Court also followed *Metropolitan Life*'s holding that because a purpose of the insurance savings clause was to preserve the McCarran-Ferguson Act's reservation of business of insurance to the States, the three factors used to determine whether a state law regulates the business of insurance within the meaning of the McCarran-Ferguson Act are also relevant to the ERISA determination. *Metropolitan Life*, 471 U.S. at 744 n.21. Pet. App. 16a-17a.

The Court's specific finding that the independent review provision of the Illinois HMO Act is a state law which regulates insurance is manifestly correct. The Court properly concluded that

> as a matter of common sense, §4-10 of the HMO Act regulates insurance because the law is directed to the HMO industry as insurers. We previously have explained that HMOs "are insurance vehicles under Illinois law," *Andersen v. Humana*, 24 F.3d 889, 892 (7th Cir. 1994), and §4-10 of the HMO Act is aimed exclusively at members of the insurance industry, even if the law does not affect the entire insurance industry in Illinois.

Pet. App. 17a.

The Seventh Circuit also ruled that the HMO Act regulates insurance under a common sense understanding



because the Act goes to the core of the relationship between the insurer and the insured. This is because insurance law provides that valid statutory provisions become part of all contracts of insurance to which they are applicable and become a part of the contract as if actually incorporated therein. Pet. App. 17a. The Court specifically ruled in accordance with *UNUM*, 526 U.S. 374, 375 n.5, that "when a law mandates a contract term between parties, whether that term is characterized as creating a procedural or substantive right, that law is integral to the insurer/insured relationship." Pet. App. 17a-18a. The Seventh Circuit decision is correct. The Petition should be denied.

**E. The Department of Labor Supports the Decision Below.**

Finally, Petitioner cites recent Department of Labor regulations relating to the provision of independent review. Petitioner notes that the Department of Labor's new regulations "do not preempt state external review laws." Pet. 21-22. What Petitioner does not tell the Court, however, is that the Department of Labor has already taken a position on the specific issue before the Court. As the government entity responsible for interpretation and enforcement of the ERISA laws, the Department of Labor as amicus below asserted that the Illinois Independent Review statute is not preempted, but is saved from preemption by the savings clause, and should be permitted to be enforced via ERISA. In the amicus brief, the Secretary of Labor specifically argued that:

> The District Court erred by holding that §4-10 of the Illinois HMO Act is not saved from preemption under ERISA §514(B)(2)(a) as a law regulating insurance.

Dept. of Labor Amicus Brief, 8.

It was also argued that:

> Like the notice — prejudice rule in *Ward*, §4-10 "effectively creates a mandatory contract term" that requires the HMO to provide independent review of benefit denials; something the HMO would not otherwise have provided.

Amicus Brief, 14. It was also argued that:

> §4-10 merely requires HMOs to establish a particular mechanism for deciding what the HMO must cover where a dispute arises between the HMO and the primary care physician. The statute neither provides Petitioner with an additional remedy where the HMO refuses to provide the covered service nor an alternative forum in which a participant can obtain the service. In order to enforce a claim for those benefits, the participant still must bring an action under §502(a)(1)(b), which therefore remains "the sole launching ground for an ERISA" benefits claim. *Ward*, 119 S.Ct. at 1391. As in *Ward*, §4-10 simply supplies the "relevant rule of decision" for Moran's §502(a) suit. *Ward*, 119 S.Ct. at 1391. That reasoning is dispositive in this case.

Amicus Brief, 18. Thus, contrary to Petitioner's argument, there is no confusion about the Federal government's view of the preemptive effect of ERISA in this circumstance. ERISA does not preempt.



## II.

## THE ARGUMENTS BY THE DISSENT ARE CONTRARY TO SUPREME COURT PRECEDENT.

The arguments made by Justice Posner in dissent to the denial of *rehearing en banc* below have been previously rejected by this Court or are simply wrong. They do not support the Petition.

Justice Posner repeatedly claims the Illinois law effects a change in the employer's ERISA plan. Pet. App. 25a, 26a, 27a. This is simply not so. Illinois law requires that an HMO *insurer* provide independent review via § 4-10. It does not *require* that any ERISA covered plan which purchases insurance must purchase insurance which provides for independent review. Rather, *if* an ERISA-sponsored, fully insured plan purchases HMO coverage in Illinois, that coverage will have as a contract term, independent review as set forth in § 4-10. Nothing in this scheme offends ERISA and it is not preempted. Rather, just like the minimum health care benefits requirement under Massachusetts law reviewed in *Metropolitan Life*, 471 U.S. 724, or just like the notice — prejudice rule reviewed by this Court most recently in *UNUM*, 526 U.S. 358, Illinois requires insurers to provide independent review in HMO insurance policies in Illinois. ERISA-sponsored plans are free to purchase or not purchase such insurance. They may self-insure. They may provide traditional, fully insured coverage. They may provide PPO coverage. But in the event they choose HMO coverage in Illinois, that coverage and that *insurance contract* will include an independent review provision as required by § 4-10. This is the classic state regulation of insurance specifically exempted from ERISA preemption by Congress.

The plan does not change. The plan provides an insurance product as one of its benefits. If that insurance product is an HMO insurance plan, it will include an independent review provision. The plan still provides insurance. The terms of the insurance are simply regulated by state law. The Seventh Circuit is correct. There is no reason to review this decision.

Justice Posner implies that the Illinois law somehow directly regulates ERISA plans because "it is a regulation of HMOs which are the service providers under a great many ERISA benefit plans." Pet. App. 25a. Yet, this Court in *California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 327 n.5 (1997), found a state apprentice wage law was not preempted by ERISA even though virtually all of the apprenticeship programs at issue appeared to be under ERISA plans.

Justice Posner complains the Illinois law adds procedural burdens which undermine federal uniformity in the administration of ERISA plans. This Court rejected that argument in *Metropolitan Life*, 471 U.S. at 747 ("We also are aware that applicants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress."). *See also UNUM*, 526 U.S. at 376 n.6. Any claimed "disuniformity" is a risk that Congress specifically accepted when it exempted state insurance regulation from ERISA preemption. The law does not undermine the statutory purpose of federal uniformity in the administration of ERISA plans because state insurance regulation was specifically exempted from such regulation.



*See UNUM*:

> We reject *Unum*'s suggestion that because the notice-prejudice rule regulates only the administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See*, *Metropolitan Life*, 471 U.S. at 728, n.2 (including laws regulating claims practices and requiring grace periods in catalogs of state laws that regulate insurance).

*UNUM*, 526 U.S. at 375 n.5.

Justice Posner finally suggests the Illinois law will increase the costs of insurance to ERISA plans. The Court also rejected that argument for preemption in *Travelers Ins. Co.*, 514 U.S. at 661 ("Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in §514(a) out of the statute. . . .") and *DeBuono*, 520 U.S. 816 ("Any state [law] . . . that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the Federal statute.").

## III.

## THE COURT SHOULD NOT HOLD THIS CASE PENDING DISPOSITION OF THE CORPORATE HEALTH CASE.

Petitioner relies heavily on *Corporate Health Ins.*, 215 F.3d 526, in support of its petition for certiorari on the basis that *Corporate Health* is inconsistent with the holding in Moran below. The *Corporate Health* case however, was decided on a sterile record, based on a challenge to the statute as a whole. It was not based, as here, on an individual insured's action for coverage of a specific procedure under a particular insurance policy. Because of the differences between that case and this one, its outcome will have no dispositive effect on this case.

First, here the insurer voluntarily incorporated the Illinois law into its policy. Pet. App. 21a n.4. In *Corporate Health*, no specific insurance policy was considered, so the decision has no bearing on the effect of ERISA preemption with respect to a voluntary contract term.

Second, the policy here was fully insured and thus is not "deemed" to be the plan itself for preemption purposes. Again, in *Corporate Health*, the Court was not confronted with any particular insurance policy, so it could not address the specific issue of the effect of the savings clause on a fully insured policy, not subject to the "deemer" clause. Supreme Court review of the *Corporate Health* case will not dispose of this action and the Court should not hold this case pending disposition of that matter should it be accepted for review.



## IV.

## RUSH'S OTHER ARGUMENTS ARE WRONG AND DO NOT SUPPORT REVIEW.

Rush still argues § 4-10 is not the regulation of insurance. Pet. Brief 23-24. It is, as discussed in § I.D above and as noted by the unanimous Seventh Circuit decision below (Pet. App. 14a-19a) and by the Petitioner's own citation to the Fifth Circuit decision in *Corporate Health*. Even the dissent to denial of rehearing *en banc* below does not dispute this conclusion. Pet. App. 24a-27a.

Finally, Rush cites Justice Posner's dissent that this is a single issue case in support of its request for review. It is not a single issue case, however, as Plaintiff raised the alternative claim below, both in the trial court and on appeal, that Rush acted in an arbitrary and capricious manner in denying coverage, an inherently factual and case-specific inquiry. Moran's App. Brief, pp. 31-42. Indeed, Plaintiff's third statement of issue presented for review below was:

> Assuming jurisdiction *arguendo*, is there a question of fact about whether Defendant acted arbitrarily and capriciously in denying the medical necessity of Plaintiff's surgery, contrary to the conclusions of the independent reviewer, treating surgeon and primary care physician.

App. Brief, p. 1. Thus, Supreme Court review will not be entirely dispositive of even this case.

## CONCLUSION

For all these reasons, Respondent respectfully submits the Petition should be denied.

Respectfully submitted,

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